

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date _____

Child's Name: _____ Date of Birth: _____

Managed Care Organization: _____ Child's Medicaid #: _____

Ages 3 – 5 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often wet or soil his pants?..... ☐ Yes ☐ No

Does your child have problems at day care or school? ☐ Yes ☐ No

Do you have any concerns about your child:

Daydreaming?..... ☐ Yes ☐ No

Paying attention?..... ☐ Yes ☐ No

Sitting still?..... ☐ Yes ☐ No

Does your child:

Refuse to obey? ☐ Yes ☐ No

Refuse to play with others?..... ☐ Yes ☐ No

Does your child get tired easily? ☐ Yes ☐ No

Does your child often seem:

Sad?..... ☐ Yes ☐ No

Angry?..... ☐ Yes ☐ No

Nervous or afraid?..... ☐ Yes ☐ No

Cranky?..... ☐ Yes ☐ No

Not interested?..... ☐ Yes ☐ No

Does your child have trouble sleeping? ☐ Yes ☐ No

Does your child have problems with eating? ☐ Yes ☐ No

Is your child often mean to animals or smaller children? ☐ Yes ☐ No

Is there a history of injuries, accidents? ☐ Yes ☐ No

If yes, please specify: _____

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MARYLAND HEALTHY KIDS PROGRAM

Maryland Department of Health and Mental Hygiene

HealthChoice and Acute Care Administration, Division of Children's Services

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Is there any history of maltreatment or abuse? ☐ Yes ☐ No

If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child? ☐ Yes ☐ No

Moving? ☐ Yes ☐ No

Divorce or separation? ☐ Yes ☐ No

Death of a close relative? ☐ Yes ☐ No

Fired or laid off? ☐ Yes ☐ No

Legal problems? ☐ Yes ☐ No

Others (Please specify): _____

Do you have other parenting concerns? ☐ Yes ☐ No

Please specify: _____

Provider: Give details of all **Positive** findings.

Provider's Signature

Date

Provider's Phone: (____) / ____ / ____

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **MD Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

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